REQUEST FOR RESTRICTION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

INSTRUCTIONS:

Complete this form, or submit the information requested in any other written form to:

Director
Employee Insurance Program
1201 Main Street, Suite 300
P.O. Box 11661
Columbia, S.C. 29211

Please note that the Employee Insurance Program (EIP) is not required to agree to your request. An administrative fee may be charged for expenses incurred in implementing your restrictions of use and disclosure.

Name: _____ ID Number: __ __ __ / __ __ / __ __ __ __

Address: _____
(Street, P. O. Box)

_____
(City, State, Zip Code)

Telephone Number: _____ Date: _____

Describe the protected health information (PHI) for which you would like to have the use or disclosure restricted.

_____

_____

Indicate how you would like to restrict the use or disclosure of your PHI.

_____

_____

When may this restriction on use or disclosure be terminated?

_____

Signature: _____

BCB-EIP Form 04-03-4